



Attached to this form is the current description of the essential functions of the position occupied by \_\_\_\_\_ (employee name), including the physical and mental demands of the job. Please answer the following questions regarding the employee's condition as it relates to the essential functions and possible accommodations. The employee's signed Release is also attached.

- ADA Reasonable Accommodation Request: Health Care Provider Information Form

4. Are there any accommodations that in your opinion would allow the employee to perform the essential functions of the job? If so, describe those accommodations.
  
  
  
  
  
  
  
  
  
  
5. If the employee cannot perform the essential functions of this position with or without an accommodation, what type of work, if any, can the employee perform with or without an accommodation? Please be specific.
  
  
  
  
  
  
  
  
  
  
6. Is the need for accommodation likely to be temporary or permanent? If temporary, how long do you estimate the need for accommodation will exist?

\_\_\_\_\_  
Provider name (Please print)

\_\_\_\_\_  
Professional license or specialty

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **ADA DEFINITION OF DISABILITY**

***Under the ADA, a person with a disability is defined as follows:***

1. "an individual with a physical or mental impairment that substantially limits one or more major life activities"
2. "an individual with a record of a substantially limiting impairment"
3. "an individual who is perceived to have such an impairment"

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